

14965

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 12 1943

Registration District No. 258

Primary Registration District No. 5821

Registrar's No. 16

1. PLACE OF DEATH:

(a) County New Madrid  
 (b) City or town Matthews, Rural - Big Prairie Twp.  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community 1 Month  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 92

(a) State Missouri (b) County New Madrid  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL.")  
 (d) Street No. Southwest of Matthews  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arine Reese

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 7  
 year 1943 hour 6 minute 30 A.M.

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 12 (Month) 1941 (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
	<u>14</u>		_____ hr. _____ min.

Immediate cause of death Pneumonia ✓

Duration \_\_\_\_\_

9. Birthplace Aberdeen, Mississippi  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name J. T. Reese

13. Birthplace Monroe Co. Mississippi  
 (City, town, or county) (State or foreign country)

14. Maiden name Sallie Dodd

15. Birthplace Monroe Co. Mississippi  
 (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant J. T. Reese

(b) Address Matthews, Mo. Rural

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/43  
 (Month) (Day) (Year)

(c) Place: burial or cremation Matthews, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director John Albritton

(b) Address Sikeston, Mo.

19. (a) April 22, 1943 (Date received local registrar) (b) W. C. Spiller (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature W. C. Spiller (M. D. or other) \_\_\_\_\_

Address Sikeston, Mo. Date signed 2-20-43

1651 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 2  
X28390

RECEIVED

District Health Office No. 2  
District File Number 543-674  
Date Filed 5-11-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Not Embalmed*, Registered Apprentice No.....  
working under my personal supervision.

Signed.....  
*G. Albritton*

Licensed Embalmer No. *4210*

P. O. Address.....  
*W. K. K. K.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

ASHLE BFWL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14965  
Registrar's No. 16

Registration District No. 238

Primary Registration District No. 5821

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 1 month years, months or days

3. (a) PRINT FULL NAME Arine Reese

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 16 (Month) (Day) (Year)

8. AGE: Years 1 Months 2 Days \_\_\_\_\_ (If less than one day) min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) (State Mo.) (b) County New Madrid  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day \_\_\_\_\_ Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I know how he/she lived on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Pneumonia  
Due to bronchial  
infection & whooping  
cough  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 9  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

ONLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

S-14965